OMB No. 1615-0032

U.S. Department of Homeland Security
Bureau of Citizenship and Immigration Services

I-690, Application for Waiver of Grounds of Excludability

INSTRUCTIONS

1. What Is the Purpose of This Form?

This form is used to apply for a waiver of inadmissibility by an applicant for adjustment of status under section 245A or 210 of the Immigration and Nationality Act (INA).

A separate waiver application must be filed by each applicant who is inadmissible. All applications must be typed or clearly printed in black ink and completed in full. If extra space is needed to answer an item, attach a continuation sheet and indicate your name, "A" file number and item number.

2. Special Instructions for Individuals Applying for a Waiver of one or More of the Medical Grounds Under Section 212(a)(1)(A) of the INA.

A. Applicants who Require a Waiver for Human Immmunodeficiency Virus (HIV) or Tuberculosis (TB).

The physician or medical facility that will provide the required treatment to you must fill out Part C of the accompanying TB/HIV supplement. If that physician or health care facility is not part of the state or local health department, then the local health department in the jurisdiction where you will reside must also complete and sign Part D. If you are outside of the United States, a relative in the United States must complete this process for you.

After the TB/HIV supplement has been completed, attach the supporting documents and file your waiver application. If you are inadmissible because of HIV and/or TB and your waiver application does not include a properly completed HIV/TB supplement, your waiver application will be returned to you.

B. Applicants Requesting a Waiver of the Vaccination Requirements of INA 212(a)(1)(A)(ii)

If your waiver application is based on religious or moral objections to vaccinations, you must establish that:

- You object to vaccinations in any form; and
- You object because of your religious beliefs or moral convictions (you do not need to be a member of a "mainstream" or recognized religion); and
- Your beliefs are sincere.

At a minimum, you must submit a personal statement describing the basis of your objection.

You can apply for a waiver of the vaccination requirements without filing this form and without paying a fee, if:

- You initially did not submit proof that you have received the required vaccines, but you are vaccinated now; or
- It is not medically appropriate for you to have one or more of the missing vaccines. The physician will make this certification according to the applicable regulations published by the Department of Health and Human Services (HHS) and the accomapnying technical instructions for physiicans designated to perform the required medical examination. These instructions are published by the Centers for Disease Control and Prevention (CDC). According to these technical instructions, "not medically appropriate" covers the following situations:
- The vaccination is not recommended by the Advisory Committee for Immunization Practices (ACIP) for your age group; or
- The vaccination is medically contraindicated; or
- There is an insuffficient interval between doses for vaccines requiring a series of doses; or
- It is not the flu season (for the flu vaccine only).

C. Applicants Who Have a Physical or Mental Disorder With Associated Harmful Behavior - INA 212(a)(1)(A)(iii)(I) or (II).

If the examining physician determines that you have a physical or mental disorder with associated harmful behavior, or a past history of a physical or mental disorder with harmful behavior that is likely to recur, the medical examination report completed by the designated physician will, at a minimum, contain the following information, as required by HHS regulations at 42 CFR part 34 and the accompanying technical instructions published by the CDC:

- A complete medical history, inlcuding the details of any prior or current hospitalization, treatment, or care;
- The current findings, diagnosis, and prognosis; and
- Any other information necessary for the CIS to determine, in consultation with HHS, the terms and conditions that should be imposed on the waiver, if it is granted.

D. Applicants Who Are Inadmissible Because of Substance or Drug Abuse or Substance or Drug Addict - INA 212(a)(1)(A)(iv)

The designated physician will determine whether you are currently using, or have used in the past, any controlled or psychoactive substance. The examining physician will make this determination during the required medical exam, according to the applicable HHS regulations at 42 CFR part 34 and the accompanying technical instructions published by the CDC.

If you are inadmissible under INA 212(a)(1)(A)(iv) due to drug abuse or drug addiction, you may apply for a waiver.

The CIS will exercise discretion in determining whether to grant this waiver, after consulting with HHS, and if you are not inadmissible on any other grounds that cannot be waived.

You are not inadmissible under INA 212(a)(1)(A)(iv) if the designated physician that performed the required medical exam determined that you are in remission for prior drug use or abuse or that your prior drug use was strictly experimental. The designated physician will detemrine whether any prior drug use is in remission, or whether it was strictly experimental, based on the applicable HHS regulations and the accompanying technical instructions published by the CDC.

Note the following key items:

- If you engaged in the use of any controlled substance, and such use was illegal at the place where it occurred, your admission to the examining physician may be sufficient to make you inadmissible on criminal grounds under INA 212(a)(2)(A)(i)(II) relating to any controlled substance violation (U.S. or foreign).
- The CIS officer reviewing your primary benefit application (Form I-687, Form I-698, Form I-700, and/or Form I-485) will determine whether this admission to the designated physician makes you inadmissible under INA 212(a)(2)(A)(i)(II).
- The only drug offense under INA 212(a)(2)(A)(i)(II) that can be waived is one offense of simple possession of marijuana (30 grams or less).
- Any willful concealment or misrepresentation of any material fact made to procure an immigration benefit (including any willful concealments or misrepresentations made to avoid being found inadmissible under any provision), will result in the denial of this waiver application and your primary benefit application. You may also become subject to additional penalties under the law.

3. What is the Fee?

You must pay **$90.00** to file this application. The fee is not refundable, whether the application is approved or not.

Do not mail cash. A separate check or money order must be submitted for each application. All checks or money orders, whether U.S. or foreign, must be payable in U.S. currency at a financial institution in the United States. When a check is drawn on the account of a person other than yourself, write your name on the face of the check. If the check is not honored, INS will charge you $30.00.The check or money order must be in the exact amount payable to the **U.S. Department of Homeland Security,** unless:

A. You live in Guam and are filing your petition there, make the check or money order payable to the "Treasurer, Guam" or

B. You live in the U.S. Virgin Islands, and you are filing your application there, make your check or money order payable to the "Commissioner of Finance of the Virgin Islands."

4. Where Must the Application Be Filed?

You must file this waiver application with the CIS office that has jurisdiction over your primary benefit application -- Form I-687, Form I-698, Form I-700 and/or Form I-485.

5. Paperwork Reduction Act Information

An agency may not conduct or sponsor an information collection and a person is not required to respond to this collection of information unless it displays a currently valid OMB control number. The estimated average time to complete and file this application is 15 minutes per application. If you have comments regarding this form you can write to Bureau of Citizenship and Immigration Services, HQRFS, 425 I Street, N.W., Room 4034, Washington, DC 20529; OMB No. 1615-0032. **Do not mail your completed application to this address.**

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U.S. Department of Homeland Security
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For Government Use Only.

Fee Receipt Number (this application):	Fee Stamp
Alien Registration Number (A#) (this applicant):	

Applicant: See instructions before filling in this application. If you need more space to answer fully any question on this form, use a separate sheet and identify each answer with the number of the corresponding question. Type or print in black ink.

1. Family Name *(Last Name in CAPITAL)* *(First Name)* *(Middle Name)*	**2. Date of Birth** *(mm/dd/yyyy)*
3. Address *(No. and Street)* *(Apt. No.)* *(City/Town)* *(State/Country)* *(ZIP/Postal Code)*	
4. Place of Birth *(City or Town and County, Province or State)* *(Country)*	**5. U.S. Social Security Number**
6. Date of Visa Application *(mm/dd/yyyy)* **for:** ☐ Permanent Residence ☐ Temporary Residence	**7. Visa applied for at:**

8. I am applying for a waiver of:

☐ 212 (a) (1)(A)(i), (ii), (iii) or (iv)
☐ 212 (a)(2)(C)(i)(II) - possession of marijuana, 30 gms or less
☐ 212 (a)(6)(A)(i)
☐ 212(a)(6)(C)(i) or (ii)
☐ 212(a)(6)(D) and/or (E)
☐ 212(a)(8)(A) and/or (B)
☐ 212(a)(9)(A)(i) or (ii)
☐ 212(a)(9)(B)(i)(I) or (i)(II)
☐ 212(a)(9)(C)(i)(I) or (i)(II)
☐ 212 (a)(10)(A), (B), (C), (D), and/or (E) - Please specify: _____

9. List reasons of excludability:

10. List all immediate relatives in the United States *(parents, spouse and children):*

Name	Address	Relationship	Immigration Status

11. I should be granted a waiver because: *(Describe family unity considerations or humanitarian or public interest reasons for granting a waiver). If more space is needed attach an additional sheet.*

12. Applicant's Signature	**13. Date**

CIS USE ONLY Recommended by:

(Print Name and Title) _____ Date _____

Signature _____ *Stamp #* _____ Director _____

Supplement for Applicants With Human Immunodeficiency Virus (HIV) Infection or Tubercoulosis (TB)

Part A. Applicant's Sponsor in the U.S.

1. Make arrangements for the applicant's medical care and have the attending physician or facility complete Part C.

2. Obtain the necessary endorsements.

a. Treatment is being provided by a state or local health department: If a state or local health department will provide the necessary care and/or treatment to the applicant, that facility should check block (a) in Number 4 under Part C. The health department is not required to complete anything else on this form.

b. Treatment is being provided by a private physician or by any other private or public facility: If a private physician, a private medical facility, or a public medical facility (other than a state or local health department) will provide the applicant's medical care and/or treatment, that facility should check block (b) or (c) under Number 3 of Part B, as applicable. In that case, the state or local health department in the jurisdiction where the applicant will reside must also complete Part D.

3. Address in the United States where the applicant plans to reside:

Address *(Number and Street)* *(Apartment No.)*

City, State and Zip Code

Part B. Applicant's Statement

Upon admission to the United States I will:

1. Go directly to the physician or health facility named in Section B;

2. Present copies of diagnostic tests used on the visa examination to substantiate diagnosis;

3. Submit to counseling and such examinations, treatment and medical regimen as may be required; and

4. Remain under prescribed tgreatment or observation whether on inpatient or outpatient basis, until discharged.

C. Statement by Physician or Heath Facility

1. I agree to supply counseling and any treatment or observation necessary for the proper management of the applicant's condition. *(Check applicable box(es):*

☐ HIV Infection ☐ Tuberculosis

2. I agree to submit a copy of my evaluation to the Division of Global Migration and Quarantine (E03), Centers for Disease and Control and Prevention, Atlanta, Georgia 30333, and certify the following:

a. I will submit a copy of my evaluation within 30 days of the date the applicant is required to appear for evaluation and/or care; and

b. If at the end of the 30-day period the applicant fails to appear for evaluation and/or care as required, I will submit a report to that effect to the CDC.

3. Satisfactory financial arrangements have been made for the applicant's medical care and treatment. (This statement does not relieve the applicant from submitting evidence, as required by the consular officer or the CIS, to establish that he or she is not likely to become a public charge (another ground of inadmissibility under section 212(a)(4) of the Immigration and Nationality Act).

4. I represent: *(Check the appropriate box and provide the information requested below)*

a. ☐ Local Health Department

b. ☐ Other Public Health Facility

c. ☐ Private Medical Practice

5. ☐ I agree to submit a copy of my evaluation to the health officer indicated in Part D. *(Required if you checked block (b) or (c) in Number 4 directly above.)*

Name of Physician or Facility *(Please type or print)*

Address *(Number and Street)*

City, State and Zip Code

Signature of Physician Date

D. Endorsement of Local or State Health Officer (If you are a State or local health department, and you have already checked block (a) in Number 4 of Part C, you do not need to fill out Part D.)

Endorsement signifies recognition of the physician or facility for the purpose of providing care for HIV infection of Tuberculosis. If the facility physicial who signed in Part C is not in your health jurisdiction or is not familiar to you, you may wish to contact the health officer responsible for the jurisdiction, and/or the physician, before you sign this endorsement.

Official Name of Department *(Please type or print)*

Signature Date

Name of Health Department to Receive the Required Notice from the CDC Following the Applicant's Arrival in the U.S./Adjustment of Status. *(Please type or print)*

Address *(Number and Street)*

City, State and Zip Code